How to Keep Your Job: Understanding Reimbursement and Knowing Your Value

Musculoskeletal Galaxy

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AAPA
American Academy of Physician Assistants

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Although every reasonable effort has been made to assure the accuracy of the information herein, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of the service and those submitting claims.

- **Medicare policy changes frequently. Be sure to keep current by accessing the information posted by your local Medicare Administrative Contractor and by CMS on www.cms.gov.**
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Aligning Practice Models for the Future

- Many hospitals, health systems and practices were shifting their business/operations model before the pandemic.
- That shift includes transforming care delivery models, re-designing locations of care, developing payer-provider partnerships and adjusting to value-based care and payment arrangements.
- During and post-COVID, there may be an enhanced need to accelerating cost-containment efforts, maximize reimbursement, better understand and manage risk, and improve workforce efficiencies.

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Revenue Cycle Management

- Fiscal/financial process put in place to manage the administrative activities and functions associated with claims processing, reimbursement and revenue generation.

- Can start when a potential patient first attempts to make an appointment (wait times/scheduling, available health professionals, determining if the patient is in your network and has active coverage).

- Knowing the rules (billing, coding and coverage) of submitting claims to different payers with potentially unique requirements.

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Revenue Cycle Management

- Maximizing payer contracts - - be intentional about the utilization, opportunities and reimbursement for PAs.
- Understand PA practice - - state laws and regulations, PA scope of practice, positive enhancements in Medicare/Medicaid policies.
- Avoid compliance concerns and prevent payment recoupment and penalties.

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Value-based Reimbursement (VBR): Slow Adoption

- One of the main problems is provider fear of downside risk.
- Despite optimistic "reports" Catalyst for Payment Reform

  "53% of commercial payments to hospitals and doctors in 2017 could be designated as value-oriented."
- The fact is the same report indicated:

  90% of value-oriented payments were built on fee for service, with 6% involved downside financial risk—about the same % as in 2012.

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Value-based Reimbursement

- True VBR has risk sharing. Most reimbursement models we call VBR are actually pay for performance type programs (with payments only marginally impacted by quality or cost of providing care metrics).

- In many cases, the potential loss of predictable revenue from the existing fee-for-service payment system makes a transition to an uncertain value-based model unattractive.

- Because payers are reluctant to levy large penalties against poor performers as part of a VBR model, payers have not been able to appropriately reward (incentivize) high performers.

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Value-based Reimbursement

- Accountable care organizations (ACOs) appeared to be one answer to move providers toward VBR.
- However, an April 2020 survey found that of more than 220 ACOs contacted nationwide almost 60% said they were likely to drop out of their risk-based model to avoid financial losses.
- During a financial crisis, the tendency may be to rely on more familiar business patterns, namely, fee-for-service.

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Insurers Seek to Redefine Image

- Professional insurance company association, Americas Health Insurance Plans, changing its name to AHIP.
- One insurer stated that investment in social determinants of health makes them "so much more than a health insurer."
- Anthem now views itself as views itself as a "digital health company."
- Recent consolidation, purchases and mergers have blurred the lines between payers, providers and technology services.

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Insurers Seek to Redefine Image

- Companies such as United Healthcare are insurers, but also employ large numbers of health professionals through its Optum division.
- Consumers and health professionals often have negative images of insurance companies.
- Rebranding is part of an effort to change the image of a business some feel focuses on cutting costs and finding ways to limit care.

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Direct Payment to PAs from Medicare

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Current Medicare Policy on PA Reimbursement

- Medical and surgical services delivered by PAs can be billed/have the claim submitted to Medicare under a PA's name.
- However, Medicare must make payment for those services to the PA's employer which could be a solo physician, physician group, hospital, nursing facility, ASC, professional corporation, or a professional/medical corporation substantially owned by a PA.
- There are limited examples of commercial payers paying directly to PAs/PA corporations.

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Why Is This an Issue?

- The inability to be paid directly hinders PAs from fully participating in certain practice, employment and/or ownership arrangements.
- When PAs can’t be paid directly, they are unable to reassign their payments in a manner similar to physicians and APRNs.
- Creates an unnecessary distinction between PAs and physicians/NPs.
- One of the pillars in Optimal Team Practice.

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The Benefits of Direct Payment Will Authorize PAs To

- Practice as independent contractors
- Want to work part-time or as needed without having to deal with additional administrative paperwork associated with a formal employment relationship
- Choose to own their own practice/medical or professional corporation
- Work in rural health clinics (RHCs) and want to ensure they receive reimbursement for "carved out" RHC services
- Work with staffing companies or medical groups and want the flexibility of re-assigning reimbursement for their services

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Direct Payment - Important Qualifiers

- The effective date of the provision is **January 1, 2022.**
- The change in policy applies to the **federal Medicare program** and does not necessarily change reimbursement policies of state Medicaid programs or commercial payers. AAPA will use Medicare's policy to advocate for direct payment with all other payers.
- Medicare regulations **defer to state law.** If state law or regulation prohibit a PA from receiving direct pay, those restrictions will have to be removed before Medicare will directly pay PAs.

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CMS COVID-19 Flexibilities

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Medicare Flexibilities During the COVID-19 Public Health Emergency (PHE)

- The PHE is likely to remain in effect until December 31, 2021.
- PHE flexibilities expanded the availability of telehealth services, telephone visits, increased PA/NP roles in delivering care in skilled nursing facilities and hospitals, in addition to other opportunities.
- AAPA and AANP jointly asked CMS to make many of the COVID-19 flexibilities permanent to ensure increased patient access to care.

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Examples of Flexibilities & Changes

Regulatory Change	Duration	Authority
Medicare patients do not need to be "under the care of a physician" and may be under the care of a PA/NP	Duration of PHE	Waiver
Physicians may delegate any tasks (such as physician-only requirements) in a SNF/LTCF to PAs/NPs	Duration of PHE	Waiver
PAs/NPs may provide required supervision of personnel performing diagnostic tests	Permanent	2021 PFS

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Sample of Flexibilities & Changes

Regulatory Change	Duration	Authority
PAs/NPs do not need to be licensed in the state they are performing services as a condition of Medicare payment (state laws still apply)	Duration of PHE	Waiver
Opted-out practitioners may terminate their opt-out status early and enroll as a Medicare providers	Duration of PHE	Waiver
Telehealth & telemedicine expansion and flexibilities	Duration of PHE	Waiver, IFC 1744, IFC 5531
Home Health & DME for PAs/NPs	Permanent	CARES Act, IFC 1744, IFC 5531

Reduce The Risk of Fraud and Abuse Allegations

Compliance Scenario #1

- A hospital in the Midwest paid back $210,739 for allegedly violating the Civil Monetary Penalties Law.

- The HHS Office of Inspector General alleged improper billing for services delivered by PAs but billed under the physician's name under Medicare's split/shared billing provision.

- The OIG stated the documentation requirements for a split/shared visit were not properly met. The services should have been billed under the PAs.

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Compliance Scenario #2

- A family physician repaid $285,000 to settle False Claims Act violations.
- Services provided by a nurse practitioner were billed as “incident to” under the physician’s name.
- Medicare’s “incident to” provisions were not met. The payment should have been at the 85% rate.

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Who Is Responsible?

The “chain of responsibility” is multi-faceted.

- Health professionals are responsible for claims submitted for services they deliver.
- Federal programs will typically expect recoupment/repayment from the entity that received the reimbursement.
- The biller (private billing company, practice or hospital billing staff) may also share in the responsibility if a mistake was made on their part in the electronic filing of the claim.

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Compliance

- In reality, most health professionals never see the actual paper or electronic claim being submitted to Medicare, Medicaid or other payers.
- Suggests the need for communication between all parties to ensure a basic comfort level with payer rules/requirements.
- PAs/NPs should be proactive in supplying basic reimbursement information to billers based on payer mix and the practice sites where they deliver care.

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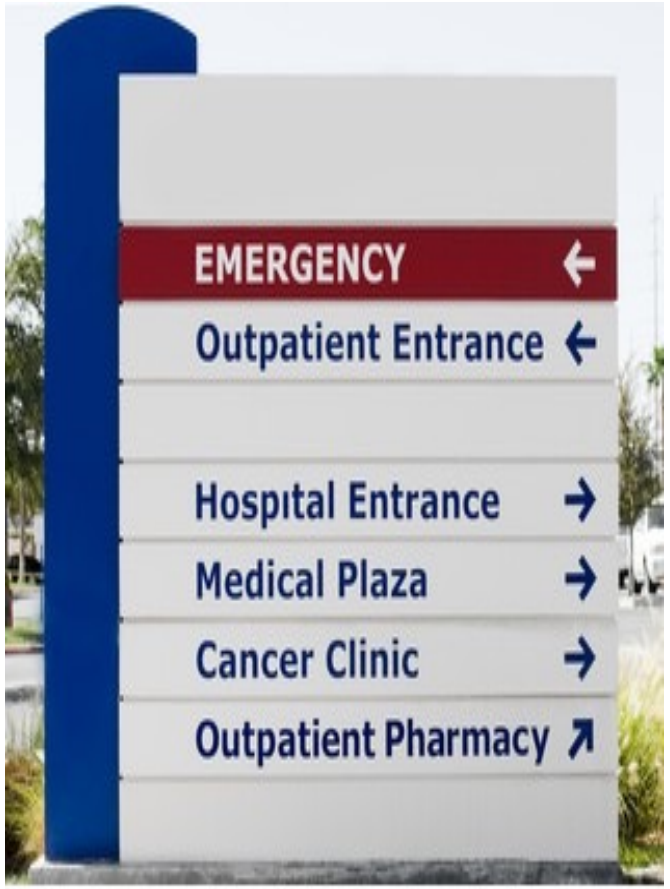
Following the Rules Depends on Your Practice Setting

Location, location, location

- Office/clinic
- Inpatient or outpatient hospital setting
- Ambulatory surgical center (ASC)
- Critical Access Hospital
- Federally Qualified Health Center/Community Health Center
- Certified Rural Health Clinic
- Skilled nursing facility,
- Inpatient rehabilitation facility or psych hospital



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Commitment to the Federal Government

On the Medicare Enrollment Application

"I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization . . . "

"I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity."

CMS 855 application https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855i.pdf

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Commitmentment to the Federal Government

On the Medicare 1500 claim form

"This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents or concealment of any material fact may be prosecuted under applicable Federal or State law."

CMS 1500 form https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500.pdf

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List of Excluded Individuals/Entities

- 

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Stark Law

- Stark law prohibits physicians from referring Medicaid & Medicare patients for certain designated health services (DHS) to an entity in which the physician or the physician's immediate family has a financial relationship, unless an exception (e.g., safe harbor) applies.

- Designated health services include clinical laboratory services, physical therapy, and home health services, among others.

- Stark requirements are specific to physicians. However, physicians can't utilize PAs or NPs to intentionally circumvent Stark law provisions.

- Proof of specific intent to violate Stark laws is not required.

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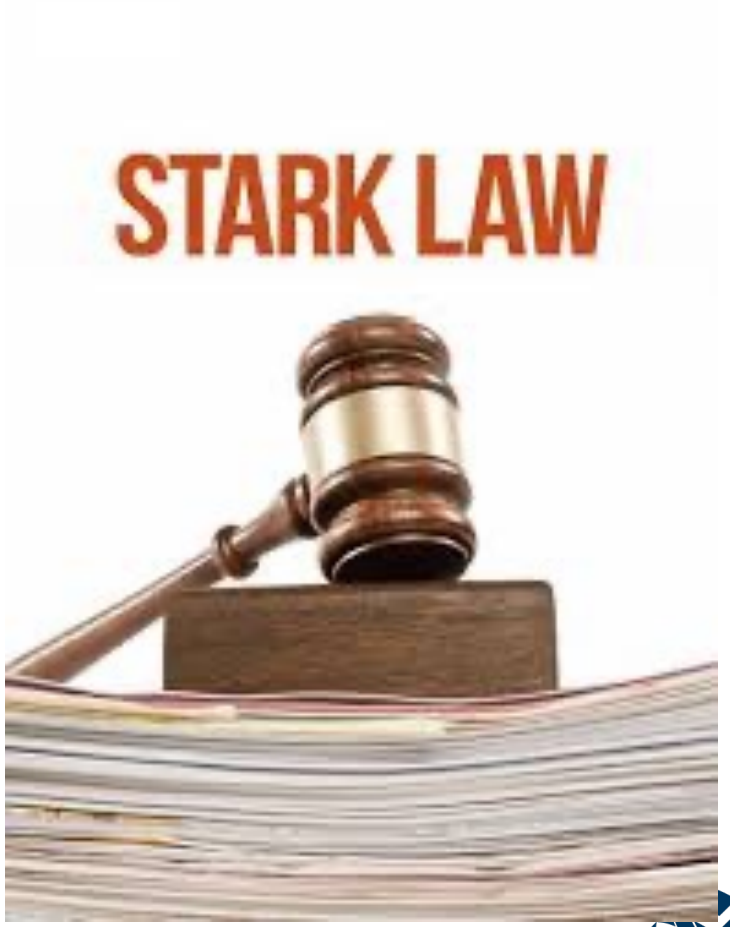
Examples of Stark Violations

- Paying unlawful remuneration to doctors in exchange for referring cardiac patients to a particular hospital.
- Hospital financial transactions with a physician practice, such as leasing office space for a price well below fair market value, with the intent of inducing referrals.
- A physician referring patients to an imaging center owned by his spouse.



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Anti-Kickback Statute

- Federal law prohibiting individuals from directly or indirectly offering, providing or receiving kickbacks or bribes in exchange for goods or services covered by Medicare, Medicaid and other federally funded health care programs.

- These laws prohibit someone from knowingly or willfully offering, paying, seeking or receiving anything of value in return for referring an individual to a provider to receive services, or for recommending purchase of supplies or services that are reimbursable under a government health care program.

- Requires some level of proof of intent.

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Examples of Anti-Kickback Violations

- A health professional who routinely waives patient copayments and deductibles to induce Medicare and/or Medicaid beneficiaries to receive services from the professional
- Payments to a health professional by a supplier (e.g., DME) to induce the purchase of Part B products from that supplier.
- Allowing reimbursement or professional services by a hospital-employed PA or NP to be received by a private physician/physician group that is not also employed by that same hospital.

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Who is Entitled to Reimbursement for a PA's/NP's Professional Work?

Who should receive reimbursement for the PA's/NP's professional services?

Only the PA's/NP's employer.

Who should receive a benefit (work product) from the PA's/NP's professional services?

Only the PA's/NP's employer.

Appropriate leasing arrangements are an option when the physician with whom the PA works is not the employer, and the physician wants to utilize the professional services of the PA/NP.

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Scenario

- Patients of a non-hospital employed physician are in the local hospital.
- A hospital-employed NP/PA is asked to deliver evaluation and management services (e.g., subsequent hospital visits or post-op care) to the non-hospital employed physician's patient in the hospital.
- There is not necessarily a problem with the PA/NP being able to provide clinical services to those patients (I would prefer some type document indicating a relationship between the PA/NP and the private practice physician)
- The question in determining if there could be a Stark/Anti-Kickback violation is who receives a benefit – either reimbursement or the benefit of professional services – from the PA/NP-provided care.

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PA's/NP's Professional Services

- Physicians who are not employed by the same entity as the NP/PA have no ability to bill/receive payment for professional work provided by PAs/NPs unless the physician provides market rate compensation (e.g., leasing arrangement) to the PA's employer.

- Any transfer of value, including NP/PA work/productivity, even if not reimbursed, must not accrue to a physician that doesn't appropriately compensate the PA's/NP's employer.

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Leasing PAs/NPs from the Hospital to Avoid Stark and Anti-Kickback Concerns

- Leasing means a written agreement between a NP's/PA's employer (e.g., hospital) and private physician or group for the PA/NP delivering specified services.
- The terms of a lease agreement should specify the type, extent and duration of services.
- Compensation for such services must be at a fair market value.
- The agreement must be signed and dated by the parties and must be updated on a regular basis to reflect changes in fair market value.

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False Claims Act

- Imposes civil liability on “any person who **knowingly** presents, or **causes** to be presented a false or fraudulent claim for payment.”
- *Knowingly* includes actual knowledge that the information is false, acting in “**deliberate ignorance**”, or **reckless disregard**” of the truth or falsity.
- “**No proof of specific intent** to defraud is required to violate the civil FCA.”

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False Claims Act

Potential Penalties

- Take back of reimbursement dollars paid
- Civil monetary penalties (up to $23,331 per incident), in addition to treble damages.
- Exclusion from the Medicare, Medicaid, and other government-related healthcare programs and imprisonment.

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Appropriate Billing

Payers polices are often unclear. Health professionals and billing/compliance staff should receive ongoing education and training.

Just because Medicare, Medicaid or a commercial payer has been reimbursing for a service doesn't mean that the organization is billing appropriately.

Pre- or post-payment audits are in use by many payers.

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Working with “Reimbursement Experts”

Get the facts. Ask for written policies, statutes, regulatory language and citations.

Don’t assume.

Realize that billing & reimbursement rules are subject to interpretation and can change frequently.

When in doubt, be conservative in your billing practices until the issue is clarified in writing with the payer.

Ultimately, those who **provide the care and submit claims for the service** are responsible for knowing and following the rules.

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The Government is Watching

Government Fraud and Abuse Programs

- Revenue Audit Contractors (RAC)
- Office of Inspector General (OIG)
- HealthCare Fraud Prevention Enforcement Action Team (HEAT)
- Zone Program Integrity Contractors (ZPIC)
- Comprehensive Error Rate Testing (CERT)

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Medicare Office-based Evaluation & Management (E/M) Outpatient Documentation

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Outpatient Level of Service Selection Based on Either

Level of E/M service based on either:

The level of the MDM (Medical Decision Making)

Total time for E/M services performed on date of encounter

Effective
January 1, 2021

Applies only to
New & Established
Outpatient
Office Visits

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Components of Care	Outpatient Documentation Requirements
History	**As medically appropriate** (not used in code selection)
Examination	**As medically appropriate** (not used in code selection)
MDM*	**Amount and complexity of problems addressed and data reviewed**
Time	**Statement of specific time spent** (ex: total time spent on date of encounter is 22 minutes)

Only 1 required for billing purposes

***If billing based on time, still need to document as medically appropriate**

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Medical Decision Making (MDM)

Levels of MDM based on:

- Number & Complexity of Problems Addressed
- Amount & Complexity of Data Reviewed
- Risk of Complications, Mortality or Morbidity

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Medical Decision Making

MDM Element	Examples of Element
Problems	One versus multiple, severity, acute versus chronic, stable or exacerbation
Data	Review of external note(s), number of tests ordered or reviewed, independent interpretation of tests
Risks	Number & type of management options, risk to patient, socioeconomic limitations, level of needed care (outpatient versus inpatient)

2 of 3 determine level of MDM

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Clinical Example #1

Established patient, is in the office for a follow-up of his diabetes and hypertension. He is on metformin 500 mg BID and lisinopril HCTZ 20/12.5 mg QD. He is doing well and has no complaints. BPs (in office and at home) and last HgbA1C were within treatment goals.

Assessment/Plan:

- Controlled hypertension. Continue current medications. Obtain a basic metabolic profile.
- Controlled diabetes. Continue current medication. Recheck HgbA1C.
- Follow up in 6 months, sooner if needed.

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2021 Table of MDM for Example #1

99203 & 99213
Low

99204 & 99214
Moderate

99205 & 99215
High

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204 99214	Moderate	**Moderate** • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or • 1 or • 1 or • 1	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* Catego • An or Catego • Inc or Catego • Disc	**Moderate risk of morbidity from additional diagnostic testing or treatment** *ples only:* rescription drug ecision regardi rocedure risk fa ecision regardi atient or proce iagnosis or trea f health

99205
99215
	High	**High**
		• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• 1 acute or chronic illness or injury that poses a threat to life or bodily function
			Extens
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				isk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

2 or more stable chronic illnesses

Any combo of 3 of the following:
***Review of each unique test (1)**
***Ordering of each unique test (2)**
*** Review of each external note from unique source**

Example: RX Drug Management

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https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

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Clinical Example #2

Established patient, has advanced dementia, stable CAD, and controlled diabetes. You saw him one month ago for his CAD and diabetes, but he is in the office with his daughter to discuss prognosis and treatment options for his dementia.

Assessment/Plan:

- Advanced dementia. Continue current medication. Reviewed previous evaluation note by neurologist.
- CAD and diabetes addressed at last office visit.
- Follow up in 6 months, sooner if needed.

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2021 Table of MDM for Example #2

99203 & 99213
Low

99204 & 99214
Moderate

99205 & 99215
High

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	Mini	inimal risk of morbidity from additional diagnostic testing or atment
99203 99213	Low	**Low** • 2 or or • 1 st or • 1 ac	Limi (Mu Cate • or Cate (For mod	w risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 1 acute illness with systemic symptoms;
		or
		• 1 acute complicated injury
			Mod
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
				oderate risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Prescription dru
				• Decision regard procedure risk
				• Decision regard patient or proc
				• Diagnosis or tre of health

99205
99215
	High	**High**
		• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• 1 acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

1 stable chronic illness

Any 2 of the following:
***Review of each unique test**
***Ordering of each unique test**
***Review of each external note from unique source (1), use of historian**

Example: RX Drug Management

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https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

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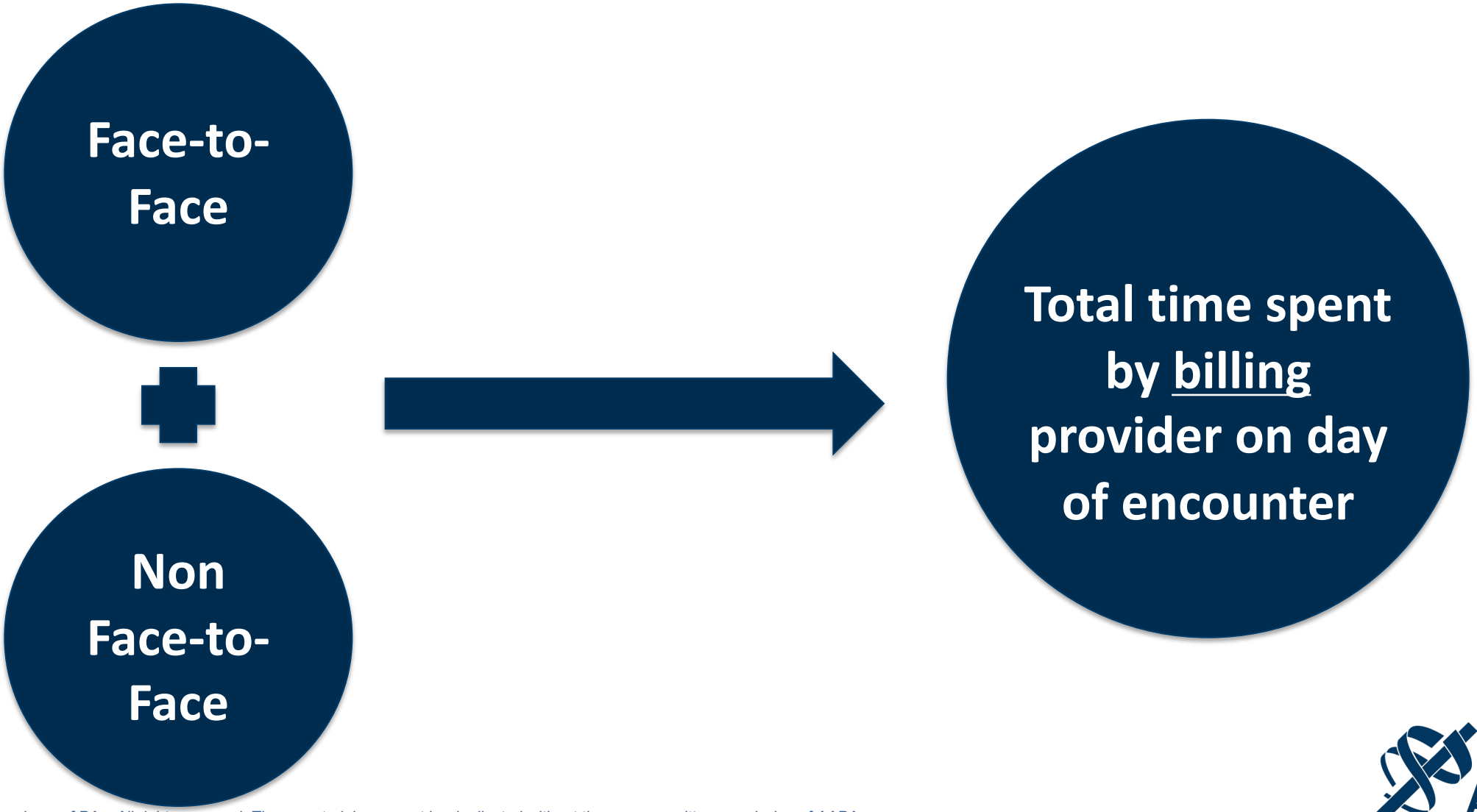
Time-Based Example



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Clinical Example #2

But . . .

- 5 minutes prior to visit spent reviewing note from neurologist and other data in the EHR
- 20 minutes spent face-to-face with patient and daughter discussing prognosis and treatment goals/options
- 20 minutes after visit spent documenting in the EHR and completing home health plan of care and certification

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Time Reporting for Office Visits

New Patient E/M Code	Total Time (2021)
99201	*code deleted*
99202	15-29 minutes
99203	30-44 minutes
99204	45-59 minutes
99205	60-74 minutes

Established Patient E/M Code	Total Time (2021)
99211	*component n/a*
99212	10-19 minutes
99213	20-29 minutes
99214	30-39 minutes
99215	40-54 minutes

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Additional Resources

- AAPA E/M Guidelines presentation now available on Learning Central
  Evaluation and Management Services in 2021

- AMA CPT E/M Office or Other Outpatient and Prolonged Services Code & Guideline Changes

  https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

- AMA CPT E/M Office Revisions Level of MDM Table

  https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

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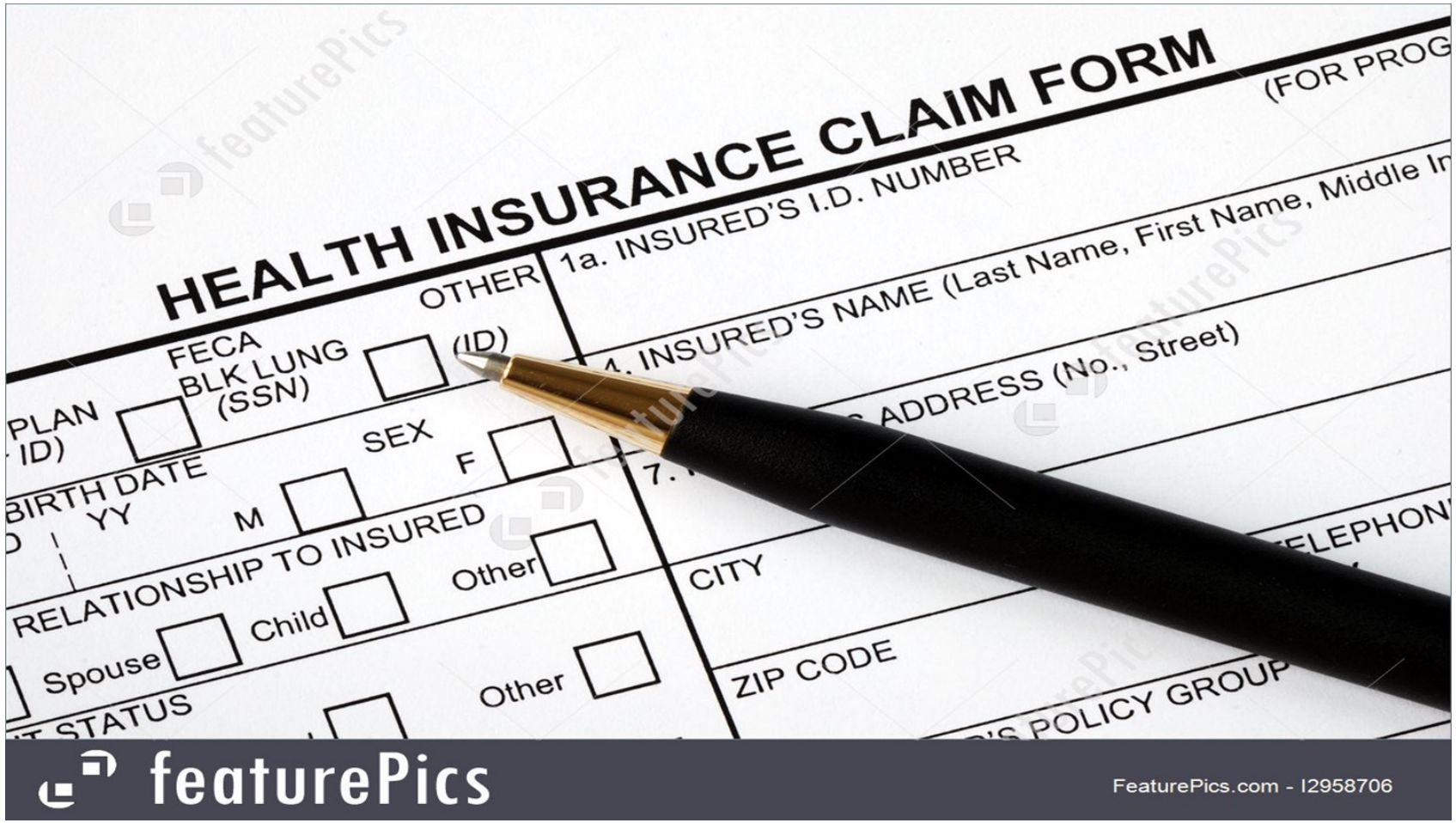
Medicare Billing Rules



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Medicare Billing Policy

Clinically practicing PAs and NPs must:

- Have an NPI number
- Enroll in Medicare
- Enroll via the PECOS system

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Current Procedural Terminology (CPT)

If authorized under the scope of their State license, PAs/NPs may furnish services billed under all levels of CPT evaluation and management codes, and diagnostic tests . . .

Medicare, Medicaid and other payers may develop policies that limit the covered services.

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PAs

- May furnish services billed under all levels of E/M codes & diagnostic tests **under general supervision** of a physician
- May bill under own name/NPI
- Reimbursed at 85%
- **PAs authorized to receive direct payment – or reassign payment as of 1/1/22**

NPs

- May furnish services billed under all levels of E/M codes & diagnostic tests **in collaboration** with a physician
- May bill under own name/NPI
- Reimbursed at 85%
- May receive direct payment – or reassign payment

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Medicare Billing Policy

- Medicare statutes
- Conditions of Participation & Payment
- Medicare Administrative Manuals
- Medicare Interpretive Guidelines
- Medicare Administrative Contractors (MACs)

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Physician Involvement & Billing

- When a PA/NP performs a professional service there may be an opportunity to bill the service under the physician's name and NPI (e.g., Medicare' "incident to" or shared services billing).

- Generally, having the physician greet the patient, stick his/her head in the exam room, co-sign the chart, or discuss the patient's care with the PA or NP does not lead to the ability to bill under the physician's name.

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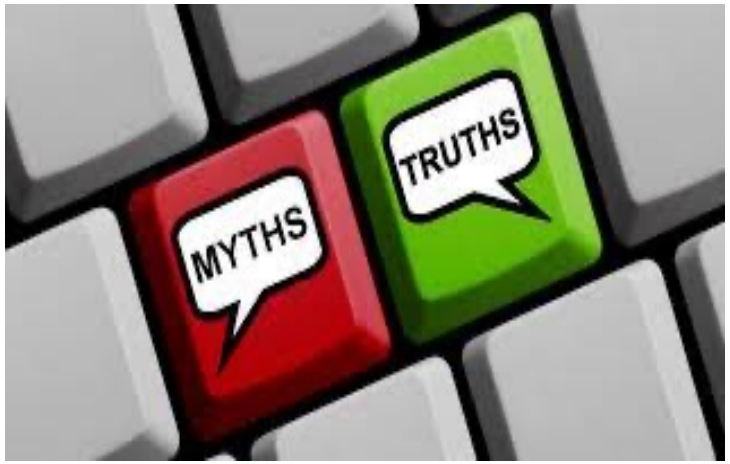
Reimbursement Myths



- PAs/NPs cannot see new patients
- Physician must be on-site when NPs/PAs deliver care.
- Physician must see every patient.
- A physician co-signature is required whenever PAs/NPs treat patients.
- Reimbursement for services provided by NPs/PAs means the practice loses money.
- Commercial payers won't cover PA/NP services.

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Billing in the Office Setting

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Office/Clinic Billing under Medicare

- PAs/NPs can always treat new Medicare patients and new medical conditions when billing under their name and NPI with reimbursement at 85% following state law guidelines.

- Medicare restrictions (physician treats on first visit, physician must be on site) exist only when attempting to bill Medicare “incident to” the physician with payment at 100% (as opposed to 85%).

- “Incident to” is generally a Medicare term and not generally applicable with private commercial payers or Medicaid.

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“Incident to” Billing

- Allows a “private” **office or clinic**-provided service performed by the PA/NP to be billed under the physician’s name (payment at 100%) (*not typically used in hospitals or nursing homes unless there is a separate, private physician office – which is extremely rare*).

- Terminology may have a different meaning when used by private payers (second notice!).

www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf

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“Incident to” Billing

Does the “incident to” provision apply to services provided in hospitals?

Medicare’s “shared visit” rules can apply in a hospital setting.

In very rare situations a hospital could house a private office.

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“Incident to” Rules

“Incident to” billing is an option, and not required to be used.

The PA/NP must be a W-2 employee or have a 1099 Independent contractor) or leased arrangement.

Requires that the physician personally treat the patient on their first visit for a particular medical condition/illness. New documentation rules allow other health professionals to contribute to the patient’s care on the first visit.

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“Incident to” Billing

The physician who initially treated the patient on the first visit (or another physician in the group) must be physically present in the same office suite.

Physician must remain engaged to reflect the physician’s ongoing involvement in the care of that patient.

How is that engagement established? Physician review of medical record, PA/NP discusses patient with physician, or physician provides periodic patient visit/treatment.

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Incident to Billing

Is there a requirement for the physician to co-sign the chart/medical record when a PA/NP delivers an "incident to" service?

Nothing in national CMS policy requiring a physician co-signature each time the PA/NP treats a patient under "incident to."

However, always follow the specific requirements of your local Medicare Administrative Contractor (MAC). A suggestion by a MAC is not a requirement.

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“Incident to” – New Problem

- Halfway through the exam, the patient tells you they have a new medical problem/condition.
- How is that new medical problem handled? Disrupt the physician’s schedule to diagnose and treat the new problem?
- PA/NP can handle the new problem at 85%?
- Now there could be one medical problem billable under “incident to” and the other problem billable under the PA/NP at 85%.

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“ Incident to”

When must a Medicare claim have PA’s/NPs name and NPI ?

- New patients
- Established patients with new problems
- Physician is not physically present in the office suite
- In the hospital setting (except for “shared visits”)

www.cms.hhs.gov/MLNMattersArticles/downloads/SE0441.pdf

www.hgsa.com/newsroom/news09162002.shtml

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“Incident to” Billing

Pitfalls for employers who bill “incident to”:

- Increased risk for fraud and abuse audits and fines.
- Potential for less efficient practice styles (reimbursement schemes determining practice style instead of clinical efficiency).
- What appears to be maximizing reimbursement often isn’t (use the time of both the PA/NP and the physician effectively; can reduce patient wait times; see a higher volume of patients by not using “incident to”)

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“Incident to” Billing

Pitfalls for PAs/NPs:

•Distorts the professional services that PAs/NPs deliver making PAs/NPs a “hidden provider.” There is no indication on claim form that a PA/NP provided the service.

•Makes PA/NP productivity and return on investment difficult to measure.

•Potentially causes PAs/NPs to not be included in current Medicare value-based payment systems such as the Quality Payments Program.

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Billing in the Hospital Setting

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Medicare – Hospital Billing

- NPs/PAs have the option to bill under their name and NPI number.
- Medicare reimbursement is 85%.
- No “incident to” billing in hospitals.

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Split/Shared Billing

Hospital billing provision that allows services performed by a PA (or NP) and a physician to be billed under the physician name/NPI at 100% reimbursement

Must meet certain criteria and documentation

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Split/Shared Billing Rules

- Services provided must be **E/M services** (e.g., subsequent visit, H&P).
  (does not apply to critical care services or procedures)

- Both PA/NP and physician must **work for the same entity.**

- Physician must provide a "**substantive portion**" and have **face-to-face** encounter with patient.

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Split/Shared Billing Rules

- Professional service(s) provided by the physician must be **clearly documented** with clear distinction between the physician's and the PA's/NP's services.

- Both the PA/NP and physician must treat the patient on the **same calendar day.**

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Split/Shared Billing

What Is a Substantive Portion?

"All or some portion of the history, exam, or medical decision-making key components of an E/M service" – CMS

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

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Split/Shared Documentation – Differing Interpretations

- Document at least one element of the history, exam and/or medical decision making (ex. CGS, NGS, Novitas)

- Physician need only document attestation of face-to-face contact with patient and that a substantive portion of service was performed (ex. Palmetto GBA, WPS)

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Split/Shared Billing

Documentation Guidance - Unacceptable

- Agree with above," signed by physician.
- "Patient seen and agree with above/plan," signed by physician.
- "Seen and examined," signed by physician.

CGS

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Split/Shared Billing

Documentation Guidance - Acceptable

- "Seen and examined and agree with above/plan," signed by physician.
- "Seen and examined" signed by physician
- "I have personally seen and examined the patient, reviewed the PAs/NPs hx, exam, and medical decision making and agree with assessment and plan," signed by physician.

WPS

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Split/Shared Billing

- No physician face-to-face encounter
- Physician failed to see patient on same calendar day
- Improper documentation
- Any other criterion not met

Bill under the PA/NP for 85% reimbursement

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Admission H&P

- It was mistakenly believed that CMS prohibited PAs/NPs from performing H&Ps or writing admission orders.
- CMS issued clarification 1/30/14 acknowledging that PAs/NPs are authorized to write admission orders and perform H&Ps.
- May be performed and billed under PA/NP name/NPI (at 85%) or under physician name/NPI if split/shared rules met (100%).

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Admissions

- Every Medicare patient must be “under the care of a doctor”, which was demonstrated by signature or co-signature of the admission order (suspended during COVID-19 PHE).
- Medicare guidance - physician co-sign admission order prior to patient discharge (1 day prior to submission of the claim if a CAH).
- Effective 1/1/19, “no longer require a written inpatient admission order to be present in the medical record as a specific condition of Medicare Part A payment.”

To cosign or not to cosign?

https://www.govinfo.gov/content/pkg/FR-2018-08-17/pdf/2018-16766.pdf
https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec482-12.pdf

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Discharges

- Time-based (< 30 min or ≥ 30 min).
- May be performed and billed under PA/NP name/NPI (at 85%) or under physician name/NPI if split/shared rules met (100%).
- *Discharge Summary used to require cosignature by a physician within 30 days of discharge.*

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CMS clarified that a discharge summary does not need to be co-signed by a physician if the following criteria are met:

PA/NP completing the d/c summary was part of the team responsible for the care of the patient while hospitalized

PA/NP is acting within their scope of practice, state law, and hospital policy; and co-signature is not required by state law or hospital policy

PA/NP authenticates the discharge summary with his or her signature (written or electronic) and the date/time

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SURGICAL PROCEDURES & ASSISTING

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Surgical Procedures

- PAs/NPs may personally perform and bill for minor surgical procedures.

- Practitioner who does the majority of a procedure is the one under whom the procedure should be billed.

Remember, procedures not eligible for split/shared billing

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2282CP.pdf

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Assisting at Surgery

- PAs/NPs covered by Medicare for first assist.
- At 85% of the physician's first assisting fee
  - Physician who first assists gets 16% of primary surgeon's fee – PAs/NPs get 13.6% of primary surgeon's fee.
- -AS modifier for Medicare.
- Be aware of list of exclusion codes (procedures for which assistant at surgery is used < 5% of the time nationwide).

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

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Assisting at Surgery

- Physician must be physically present during all **critical or key portions** of the procedure and be immediately available during the entire procedure.

- Critical portions of two surgeries performed by the same physician may not take place at the same time.

- If physician not immediately available during non-critical portions, must arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

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Assisting at Surgery – Teaching Hospitals

- Based on the Social Security Act, Medicare does not generally reimburse for first assistant fees if there is a qualified resident available

Teaching Hospital Exception allowed:

- No qualified resident available (in required training/clinic-hours or resident-hour restrictions)
- Physician NEVER uses a resident in pre-, intra-, and post-op care
- Exceptional medical circumstances (e.g. multiple traumatic injuries)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

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Assisting at Surgery – Teaching Hospitals

When no qualified resident is available:

- Physician must certify

  I understand that § 1842(b)(7)(D) of the Act (follow the link and select the applicable title) generally prohibits Medicare physician fee schedule payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by the A/B MAC (B).

- Use second modifier -82 (in addition to –AS)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

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Procedures (Office or Hospital)

- PAs/NPs are covered for personally performing procedures and minor surgical procedures.
- Can’t be shared; must be billed under the name of the professional who personally performed the procedure.
- Physical presence of the physician is not necessary for billing.

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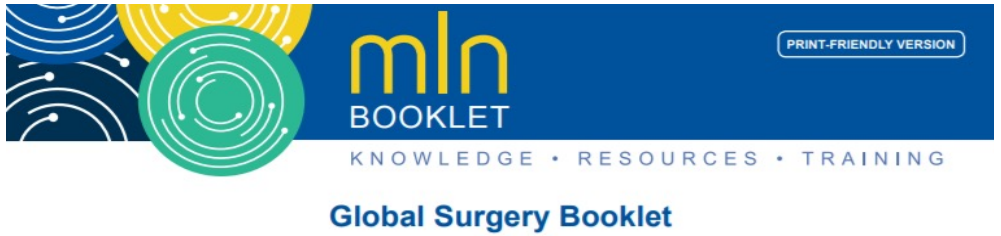
Global Surgical Package

- Bundled payment for all usual and necessary pre-, intra-, and post-operative care for a procedure or surgery.

- 10-day, and 90-day post-operative period.

- PA/NP contribution is often “hidden”



https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf

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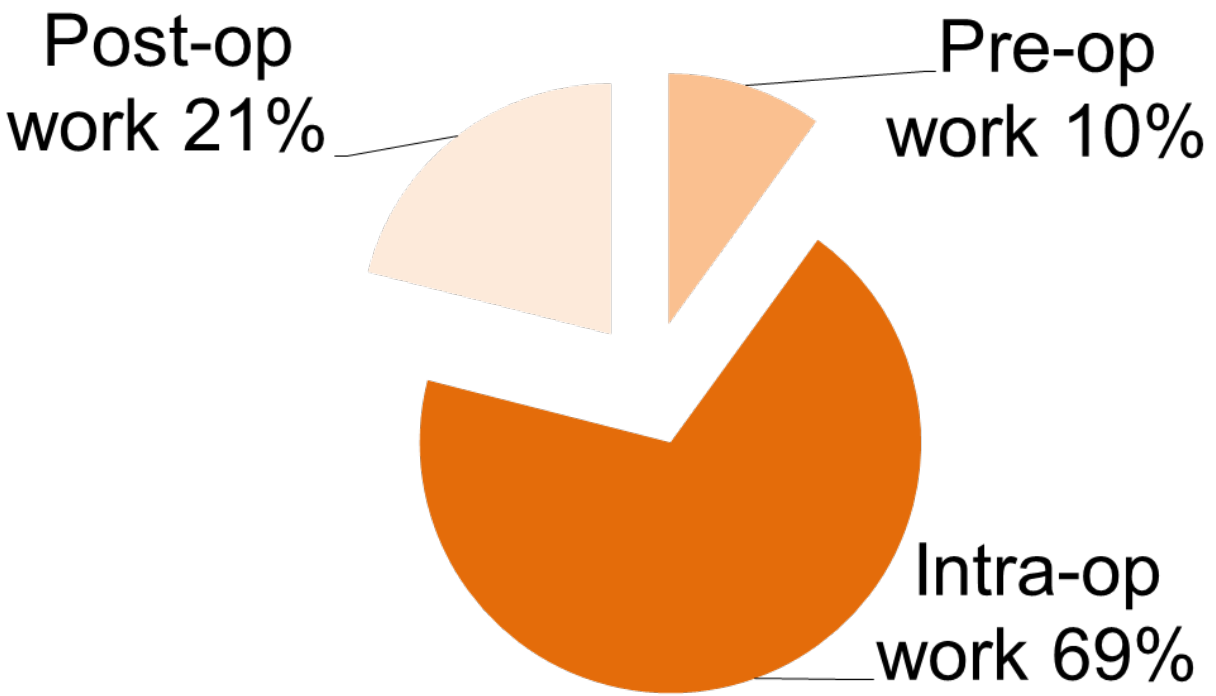
Global Surgical Package



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Physician Fee Schedule Search

Search Results [1 Record(s)]

Selected Criteria:

Year:	2016	HCPCS:	27130
Type of Info.:	All	Modifier:	All Modifiers
HCPCS Criteria:	Single HCPCS Code		
MAC Option:	National Payment Amount		

Single HCPCS Code

Code	Description
27130	Total hip arthroplasty

GLOBAL	PRE OP	INTRA OP	POST OP
090	0.10	0.69	0.21

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Global Work Contribution Calculation

- 31% of the global payment is for work outside the OR.
- If the PA/NP is doing the pre-op H&P, the post-op rounds, and the post-op office visits, then 31% of the global payment could, theoretically, be applied to the NP/PA.
- Additionally, 31% of the Work RVU attributed to the procedure could be applied to the PA/NP.

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Global Work Contribution

Example: 27130 Total Hip (payable at $1,401*)

Pre-op work (10%): **$ 140.10 → PA/NP**

Intra-op work (69%): $ 966.69 (surgeon)

Post-op work (21%): $ **294.21 → PA/NP**

*Final figure impacted by geographic index

Source: CMS Physician Fee Schedule

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Global Work Contribution

- If a PA/NP does pre-op exam and post-op rounding and office visits, **$434.31** could be “credited/allocated” to the NP/PA.
- An additional separate payment of **$190.54** can be officially credited to PA/NP for the first assist (13.6% of surgeon’s fee).
- However, billing records would show $1401 being attributed to the surgeon.

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PA/NP “Value”

True measure of global “value” might be:

First assist payment of **$190.54**

plus

E&M share of global payment **$434.31**

Total = $624.85 per THR

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CPT Code 99024

- *Postoperative follow-up visit, normally included in the surgical package*
- No separate reimbursement paid.

<u>Can be used to capture post-op work provided in Global Surgical Package</u>

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Surgery/Global Work

- While not separately payable, track “Global” visits by using the 99024 code in the EMR.
- The global visits performed by the PA/NP would otherwise have to be performed by the physician.
- If the PA/NP provided 300 post-op global visits, for example, theoretically 300 appointment slots were then made available for the physician to see other “revenue generating” visits.

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Without split/shared or incident-to billing, Medicare payment is at 85% of the physician rate.

What about that 15%

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Office/Outpatient Visit: Established Patient

15%=$12.45

CPT Code	Work RVU	Non-facility Price* Physician	Non-facility Price* PA/NP
99213	0.97	$83.00	$70.55

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Discounted Reimbursement

Contribution Margin

a) What was the cost of providing the service?

b) What was the reimbursement/revenue?

c) What is the margin?

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PA/NP-Physician Office "Contribution" Comparison Model

Assumptions:

- 8-hour days (7 clinical hours worked per day)
- 15-minute appointment slots = 4 visits per hour = 28 visits per day
- Physician salary $250,000 ($120/hr.); NP/PA salary $110,000 ($53/hr.)
- 2,080 hours worked per year

Example does not include overhead expenses (office rent, equipment, ancillary staff, etc.)

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PA/NP Contribution Model at 85% Reimbursement

A Typical Day in the Office	Physician	PA/NP
Revenue with physician and PA/NP providing the same 99213 service	$2,324 ($83 X 28 visits)	$1,975 ($70.55 X 28 visits) [85% of $83 = $70.55]
Wages per day	$960 ($120/hour X 8 hours)	$424 ($53/hour X 8 hours)
"Contribution margin" (revenue minus wages)	$1,364	$1,551

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Cost Effectiveness Takeaway Points

- The point of the illustration is not that PAs/NPs will always produce a greater office-based contribution margin than physicians.
  - ➢ That may or may not happen (more likely in primary care/internal medicine vs. surgery or specialty medicine).
- However, NPs/PAs generate a substantial contribution margin for the practice even when reimbursed at 85% of the physician fee schedule.
- An appropriate assessment of “value” includes revenue generation, non- revenue generating professional activities and the cost to employ a health professional.

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Cost to Employ

Salary	PA <physician
Benefits (PTO, CME allotment, etc.)	PA ≤ physician
Recruitment/Onboarding	PA ≤ physician
Malpractice Premiums	PA < physician
Overhead (building, staff, supplies)	PA = physician

Cost to employ PA is substantially lower

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Added Value

- PAs/NPs increase access to the practice. No reason for patients to wait 2 weeks to get an appointment when they can see the NP/PA in 3 days. Extended waits for appointments will cause some patients to seek out other practices.

- PAs/NPs can provide surgical post-op global visits, freeing up surgeons to see new patients and consults, and perform procedures which generate additional revenue.

- NPs/PAs often facilitate communications with patients, the patient's family, hospital personnel, complete forms and order medications - activities which don't show up as revenue, but are essential to an effective, patient-centered practice.

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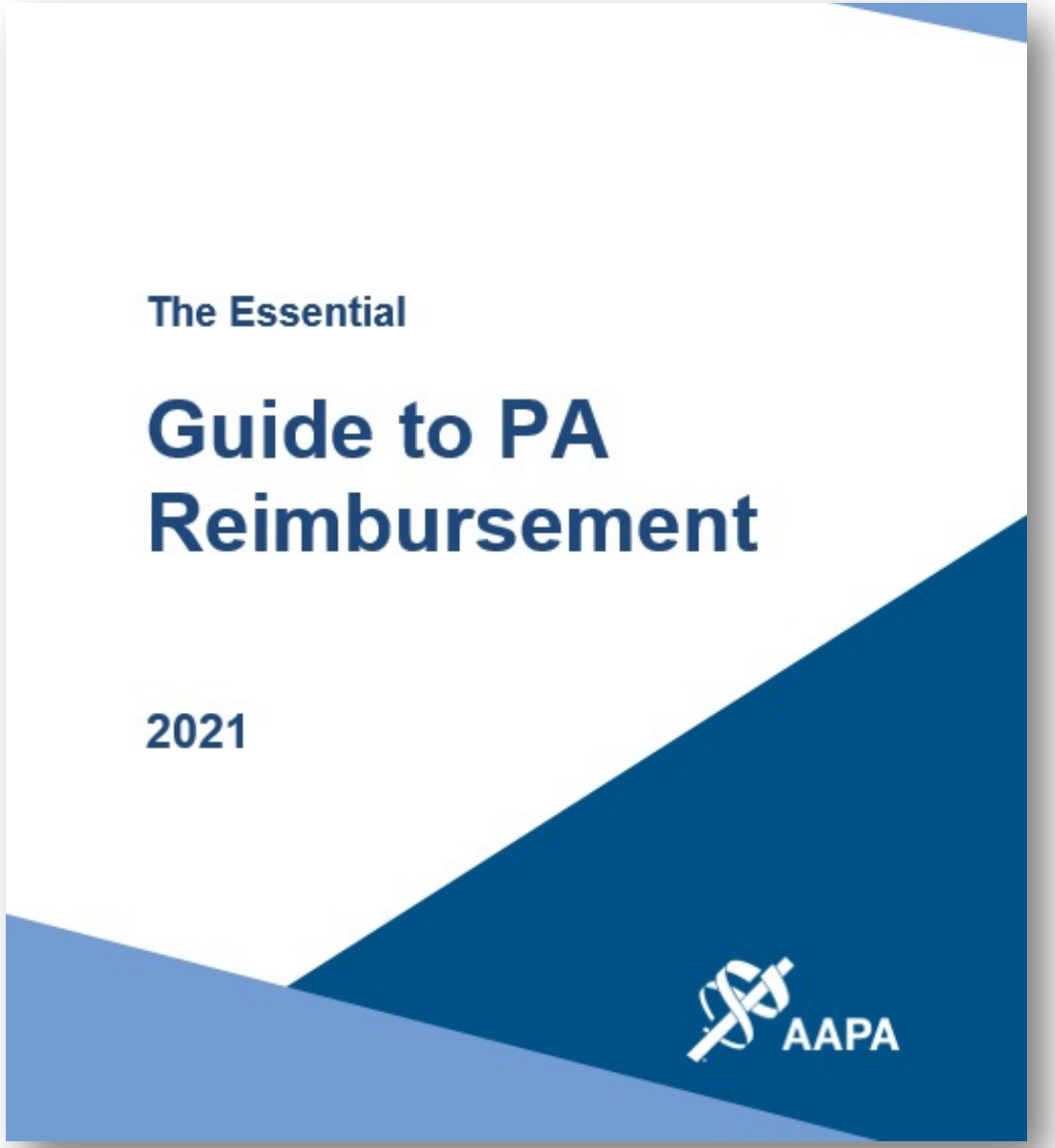

What makes it ‘essential’?

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